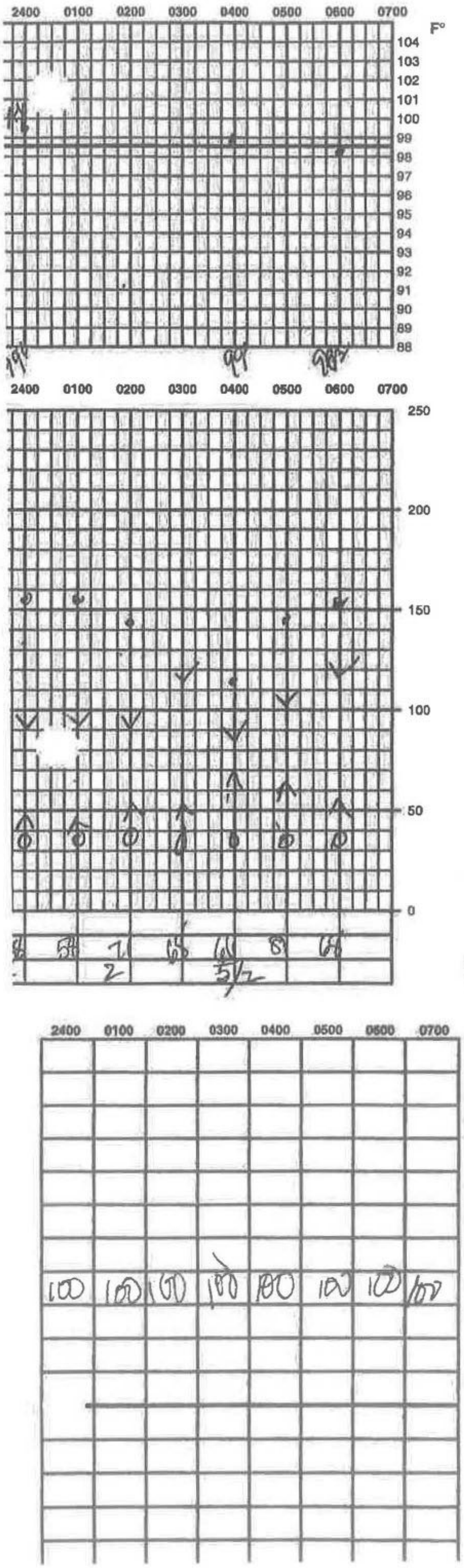

Nurses' Progress Notes

1500 Orders recieved to extubate pt. Feeds & fentanyl gtt turned off @ 1200. IMV rate decreased to 8. pt RR 20's ̄c etCO2 ̄c 40's. MD, RT, RN at bedside for extubation. pt suctioned & extubated to 2L NC sats 100 ⊕ cough, swallows secretions well. nonlabored breathing. Will monitor WOB, sats closely. JHuddleston RN

1600 Nursing outcomes #1 pt extubated @ 1500, no stridor noted at this time. Will monitor WOB sats closely. #2 No seizure activity noted at this time. cont EEG monitoring underway. pupils 3-4 brisk reactive, UAE, pt does turn head to voices. pt continues on scheduled phenobarb. Level on 4/29 was 35. plan: continue EEG for another 24°, monitor for seizures, Neuro V'S @ 2hrs. Follow up with neurology consults. outcome #3 versed d/d yesterday. Fentanyl gtt off at 1200. continues on scheduled chloral hydrate. Flacc scores 2-4, calms ̄c chloral & nursing interventions. plan: Monitor flacc scores closely. JHuddleston RN

2000 Axillary temp 100.4 Tylenol 100mg given via NDT will recheck temp frequently. Skin warm pink & dry. V. Mailer RN

0200 #1 Pt weaned from O2 by NC. Now on Room Air. O2 Sat Remain 99-100%. No noted ↑ WOB. #1 Continue to observe for Stridorous Resp for which Racemic Epi given @ ? no further Stridor presented. Pt handling own Oral & Resp Secretions now ̄c little intervention needed for Airway Clearance

#2 Continuous EEG monitoring in progress, no Clinical Seizures evident throughout night. See Neuro V flowsheet, Pupils Reactive from 4 → 3 then return to 4mm. Physician aware

MED0980

D = mcg/hr
Previous 24°

I

O

Today's Weight

Yesterday's Weight

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 1 of 4

RN JH
RN

Date 4/29/09

Assistive Devices
T - TEDS
A - Air Mattress
S - Splints
C - Compression Device

INTAKE

	0800	0900	1000	1100	1200	1300	1400	1500	8 hr Total	1600	1700	1800	1900	2000	2100	2200
Fentanyl	2	2/4	2/6	2/8	2/10				8							
NS	2	2/4	3/6	3/8	2/10	2/12	2/14	2/16	16	2	2/4	2/6	2/8	2/10	3/12	2/14
Sim. Adv.	40	40/80	40/120	40/160	0				160				40/40	40/80	40/120	40/160
meds/flush		4		4/8					8			15		3/18		
TOTAL INTAKE ➤									192							

OUTPUT

	0800	0900	1000	1100	1200	1300	1400	1500	8 hr Total	1600	1700	1800	1900	2000	2100	2200
URINE	58		dry		155		x1 wet bed		268	65	38/103	50/153	dry		42/195	
STOOL/GUIAC	x1				0		55			x1		x1			small	
GASTRIC GUIAC/PH																
CHEST TUBE																
TOTAL OUTPUT ➤									268							

PRN MEDS

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200
Fent.	2mg 0800	2 times 0940													
Tylenol		100mg 0920						100mg 1500					160mg 2002		
Chloralhydrate															
HEPARIN FLUSH															

MISC

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200
OXIMETRY PROBE SITE	Δ				Δ				Δ				did		
ACCUCHECK															
HWE/C	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Position	L	L	R	R	S	S	L	L	S	S	R	L	R		L
PROTECTIVE / SAFETY DEVICE												✓			
CIRC CHECK	✓		✓		✓		✓		✓		✓		✓		✓
ASSISTIVE DEVICE															

Total	2400	0100	0200	0300	0400	0500	0600	0700	8 hr Total
D	40/40	40/80	40/120	40/160	40/200	40/240	40/280	40/320	320
	3/3				3/6		10/16		16

TOTAL INTAKE ➤ 336

	2400	0100	0200	0300	0400	0500	0600	0700	
	40/40		160/200	52/252	62/314		dry		314
				✓	✓✓				

760

24° 829

TOTAL OUTPUT ➤ 314

2400	0100	0200	0300	0400	0500	0600	0700
100mg 0015				100mg 0415	0520 130mg		
			Xld				
✓	✓	✓	✓	✓	✓		✓
R		S		L	S	R	
✓	✓	✓	✓	✓	✓		✓

by Grandmother Bedside. — (PH3) Pain moderate Noted c̄ movement & Diaper Changes. Tylenol Given q4° this night. Calm music played in Room. (PH3) Continue to monitor VS & Pain scores acceptable levels. Chloral Hydrate / c̄ Tylenol available for Pain/anxiety relief. — Y. Marlow RN

Room Check	0700 - 1900	1900 - 0700
BAG / MASK / SUCTION / DRUG SHEET	✓✓✓✓ JH	✓✓✓✓ VRM
SIDE RAILS / BED POSITION	✓✓ JH	✓✓ VRM
Alarm Parameters ON	✓ JH	✓✓ VRM

2 RN Signatures to verify IV Drip rates

0700 ⊕ JHuddleston RN / Ø gtts ⊕

1900 ⊕ / ⊕

MED0982

VENTILATION

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200
O_2 SOURCE	SRVO							NC											
FIO_2	35							2L								↓1.5L	↓1.0L		07
MODE	SIMV PC PS																		
RATE (IMV)	28		↓23	↓18	↓13	↓8													
TV																			
PIP / PEEP	/ 5																		
PS	10																		
PC	12																		
SaO_2 (PULSE OX)																			
$ETCO_2$																			
pH																			
PCO_2																			
PO_2																			
HCO_2																			
BE																			
Art O_2 Sat (calc)																			
Art O_2 Sat (dir.)																			
VEN O_2 Sat (dir.)																			
NEB/ CPT																			
SUCTION	✓✓	✓	✓✓	✓		✓✓		✓✓	✓✓		✓						[illegible]	[illegible]	

GLASGOW COMA SCALE / NEURO

CHILD/ADOLESCENT	INFANT	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400
EYES: 4 Spontaneous; 3 Open to Speech; 2 Open to Pain; 1 Remain Closed		4		4		4		4		4			4		4		4	
VERBAL: 5 Oriented; 4 Confused; 3 Words; 2 Sounds Only; 1 No Response	Coos/Babbles; Irritable Cry; Cries to Pain; Moans to Pain	1 ETT		1 ETT		1 ETT		1 ETT		4			4		4		4	
MOTOR: 6 Obeys Commands; 5 Localizes Pain; 4 Withdraws; 3 Abnormal Flexion; 2 Extension; 1 No Response	Spontaneous Movement; Withdraws to Touch; Withdraws to Pain	5		5		5		5		5			6		6		6	
	SEDATED Y / N	Y		Y		Y		Y		Y			N		N		N	
	TOTAL	10		10		10		10		10			14		14		14	
PUPILS RIGHT: Size/Reaction	R	4B		4B		4B		4B		4B			4B		4B		4B	
PUPILS LEFT: Size/Reaction	L	4B		4B		4B		4B		4B			4B		4B		4B	
Fontanelle: Fl - Flat Fu - Full B - Bulging T - Tense S - Sunken		NA		NA		NA		NA		NA			UTA		UTA		UTA	
ARMS: 5 Normal; 4 Slightly Weak; 3 Breaks Gravity; 2 Does Not Break Gravity; 1 Flicker; 0 No Motor Response	R	4		4		4		4		4			4		4		4	
	L	4		4		4		4		4			4		4		4	
LEGS: 5 Normal; 4 Slightly Weak; 3 Breaks Gravity; 2 Does Not Break Gravity; 1 Flicker; 0 No Motor Response	R	4		4		4		4		4			4		4		4	
	L	4		4		4		4		4			4		4		4	
COUGH / GAG	+ OR -	++		++		++		++		++			++		++		++	
SUCK / SWALLOW	+ OR -	UTA		UTA		UTA		UTA		UTA			+ / UTA					
PAIN SCALE *circle method:*		cries / faces / flacc / linear								cries / faces / (flacc) / linear								

☐ System Assessed, No Problem Identified [illegible] TIME 0800 INIT JH

1. Respirations: ☐ Shallow ☐ Labored ☐ Nasal Flaring ☐ Stridor ☐ Grunting ☐ Periodic

MED0983

0500 0600 0700

Lab Values

TIME	0400							
Glu								
BUN								
Creat								
Na								
K								
Cl								
CO_2								
ICA								
Hgb								
Hct								
Plts								
WBC								
PT								
PTT								
Phenobarb	LR (31)							
Glu / Ket								
Sg / pH								
bld / prot								

Reference Range for unit based lab tests		
Accucheck: 70-100 mg/dl		
URINE DIPSTICK		
glucose	–	negative
billrubin	–	negative
ketone	–	negative
blood	–	negative
ph	–	5.0-8.0
protein	–	neg.-trace
sp. gravity	–	1.001-1.035
occult blood in stool	–	negative
occult blood in gastric content	–	negative

0000 0400 0500 0600 0700

4 4 6 N 14 4b 4b 4 4 4 4 4

flacc / linear

INIT LRN ☐ NO PROBLEM

Hours Post Dose →	0614	10 ~~1800~~				
DRUG LEVELS						
Phenobarbitol	35					
Phenobarbital		31				

PUPIL SCALE

B = Brisk S = Sluggish N = Non-react

1 2 3 4 5 6 7 8 mm

LINEAR ANALOGUE PAIN SCALE

No Pain — Excruciating Pain

0 1 2 3 4 5 6 7 8 9 10

☺ 😐 ☹

INOVA HOSPITAL FOR CHILDREN

PICU Flowsheet

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RN
RN

Date 4/29/09

0700-1900 INITIAL	1900-0700 INITIAL

MED0984

RESPIRATORY

Consistency: ☐ Thin ☒ Thick ☐ Frothy ☐ Tenacious

4. Breath Sounds: Right side — Left side

1. Clear 2. Crackles 3. Inspiratory wheezes 4. Exp. wheezes 5. Rhonchi 6. Stridor 7. Diminished 8. Absent

5. Chest Tubes: ☒ Type of Device ____ CM suction ____ ☐ Water Seal
Location ____ ☐ Tidaling ☐ Air leak ____ ☐ Straight Drainage
Character of Drainage ☐ Serous ☐ Sero Sanguinous ☐ Sanguinous ☐ Cloudy

Comment: cont RR SAT monitoring, etco2

CARDIOVASCULAR

☐ System Assessed, No Problem Identified TIME 0800 INIT HH

1. Heart Rhythm: ☒ NSR ☐ Sinus Brady ☒ Sinus Tachycardia c fevers
☐ SVT ☐ Ventricular Dysrhythmia ☐ Junctional/Nodal
Pacemaker: ☐ Temporary ☐ Permanent ☐ Transvenous ☐ Epicardial
☐ Transcutaneous Mode ____ Rate ____
MA: AO ____ VO ____ Sensitivity A ____ V ____ AV Delay ____

2. Pulses: 0-Absent 1 Weak 2 Normal 3 Bounding D-Doppler

Pulse	B	R	F	DP	PT	Carotid
R		2		2		
L		2		2		

CAPILLARY REFILL IN SECONDS

CFT: RUE	<3	LUE	<3
RLE	<3	LLE	<3

3. Heart Tones: ☐ Active Precordium ☒ Normal ☐ Murmur
☐ Gallup ☐ Rub ☐ Distant PMI ____

4. Edema: ☒ ☐ Generalized ☐ Extremity ☐ Sacral ☐ Periorbital
☐ Other ____

5. Vascular Catheters:

Line Type	Location	Date of Insertion	Device	Site Condition
PIV	(R) foot	4/28/09	☒	SL flushes well infusing, site c/d/i
PIV	(L) AC	4/27/09	pump	

PA catheter CM Insertion ____ CM Sheath ____

Comment: cont. cardiac monitoring

INTEGUMENTARY

☐ System Assessed, No Problem Identified TIME 0800 INIT HH

1. Skin Turgor: ☐ Poor ☒ Taut
2. Skin Temperature: ☐ Cool ☐ Clammy ☐ Diaphoretic ☒ Warm ☐ Hot
3. Skin Color: ☐ Pale ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☒ Pink ☐ Red/Flushed
4. Rash/Lesions: Location / Type ____
5. Pressure Ulcers: Site ____ Site in cm ____
Stage: ☐ Red Area ☐ II Partial Thickness ☐ III Full Thickness ☐ Penetration to Muscle

Incision/Wounds/Drains:
location / Condition: skin c/d/i
Comment: cont EEG monitoring

BRADEN SCALE:
Total Score: 20

15 - 16	Low Risk
12 - 14	Mod Risk
≤ 11	Hi Risk

GI / GU

☐ System Assessed, No Problem Identified TIME 0800 INIT HH

1. Abdominal Palpitation: ☒ Soft ☐ Firm ☐ Distended ☐ Tender ☐ Rigid ☐ Girth ____
2. Bowel Sounds: ☒ Active ☐ Hyperactive ☐ Hypoactive ☐ Absent
3. Gastric Tube: Type ND Size 5Fr Measures (cm) 40 ☐ To suction ☐ To gravity drainage ☒ Feeding (Intermittent/Continuous)
Type ____ Size ____ Measures (cm) ____ ☐ To suction ☐ To gravity drainage ☐ Feeding (Intermittent/continuous)
drainage: color ____ guiac ____
4. Urine Catheter: Draped ☐ External ☐ Suprapubic ☐ Indwelling size ____ Date Inserted ____
color ____ ☐ Cloudy ☐ Sediment ☐ Fruity Smell ☐ Foul Smell

Comment

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 4 of 4

RN JH
RN VRM
Date 4/21/09

NEURO	Comments: Fent gtt, sch. chloral	JH	VRM
NUTRITION	Diet: Similac 20	JH	VRM
	Formula:		
	☐ NG ☒ NJ/NJ ☐ GT ☐ po	JH	VRM
	☒ Total feed ☐ Needs assistance ☐ Feeds self	JH	VRM
ALLERGIES	NKDA	JH	VRM
PSYCHOSOCIAL	☒ Communications Barrier ETT	JH	VRM
	☐ Unable to assess: ☐ Pt. ☐ Family		
	☐ Coping Ineffective: ☐ Pt. ☐ Family		
	☐ Fears:		
	Pain ☐ Pt. ☐ Family		
	Dying ☐ Pt. ☐ Family		
	Being Alone ☐ Pt. ☐ Family		
	☐ Emotional State:		
	Anxious ☐ Pt. ☒ Family	JH	
	Agitated ☐ Pt. ☐ Family		
	Tearful/Crying ☐ Pt. ☐ Family		
	Euphoric		
	☐ Parents: ☐ Called ☒ Visited	JH	RM
	☐ Pt./Parent Teaching ☐ Return demonstration		
	Comments:		
NURSING CARE / PROCEDURES	TRANSDUCERS: level / calibrated		
	Activity: ☒ total care ☐ need assistance ☐ self care	JH	VRM
	HOB: ☐ flat ☒ 30° ☐ 45° ☐ 90°	JH	VRM
	☐ other High Falls Precautions	JH	VRM
	Bedrest / Turn Q2°	JH	VRM
	Chair / HELD		
	Ambulate ☐ on own ☐ with assist		
	ROM		
	Protective Device / RELEASE Q2°	JH	VRM
	Seizure Precautions	JH	VRM
	HYGIENE: Bath		
	Oral Hygiene	JH	VRM
	Peri / Foley Care	JH	VRM
	Skin Care	JH	VRM
	Gastric Tube Care		
	Feeding Bag Rinsed / Changed	JH	VRM
	Trach Care / Trach Changed		
	Cervical Collar Site Care		
	Line Tubing Changed / Injection Cap Changed		
	Carrier System Changed		
	IV Started / Location		
	PREP for test or procedure		
	x ray		VRM
	other		
	NURSING CARE > 16 hrs day		VRM

[redacted] G 08
FH 37373672 ACCT STRT
5M M ADM 04/20/09
[redacted] N 04305493 PADM

Admit Date 4-20-09
OR Date
Height 65 cm
Head Circ Infants under 2 yrs 43.5 cm
Ett/Trach size cuffed/uncuffed
Taped at
When placed
Retaped on

°C F° 0700 0800 0900 1000 1100 1200 1300 1400 1500
40 104 39 103 38 102 37 101 36 100 35 99 34 98 33 97 32 96 31 95 30 94 29 93 28 92 27 91 26 90 25 89 24 88
100.9 Ax

1600 1700 1800 1900 2000 2100 2200 2300
102.3 100°

0700 0800 0900 1000 1100 1200 1300 1400 1500
250 200 150 100 50 0
BP
T Art
V Cuff
RESP °
HR •
Temp •
MASP
CUFF MEAN 83 77 88/64 73 77 76 73
PAIN SCALE (1-10) 0 0 2 4 4/6 0 0

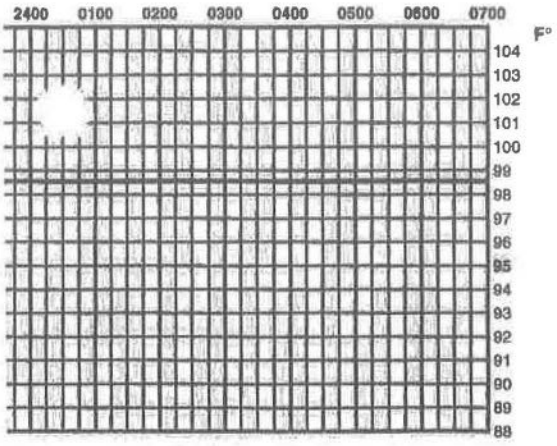
1600 1700 1800 1900 2000 2100 2200 2300
56 64 62 86 78
4/0 0 0 0

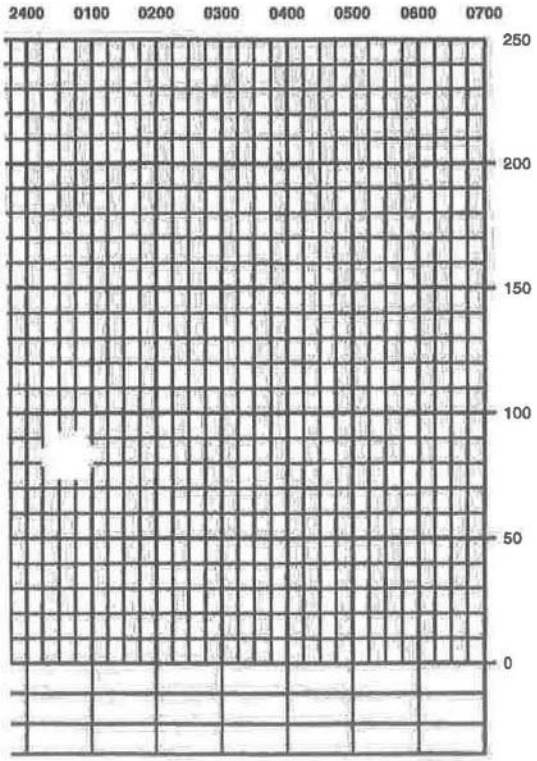
HEMODYNAMICS	0800	0900	1000	1100	1200	1300	1400	1500
CVP								
LAP								
PAS / PAD								
MPAP								
PCWP								
SVO2								
EtCO2								
O2 Sat	100	100	100	100	100	100	100	100
ICP								
CPP								
RIPS								

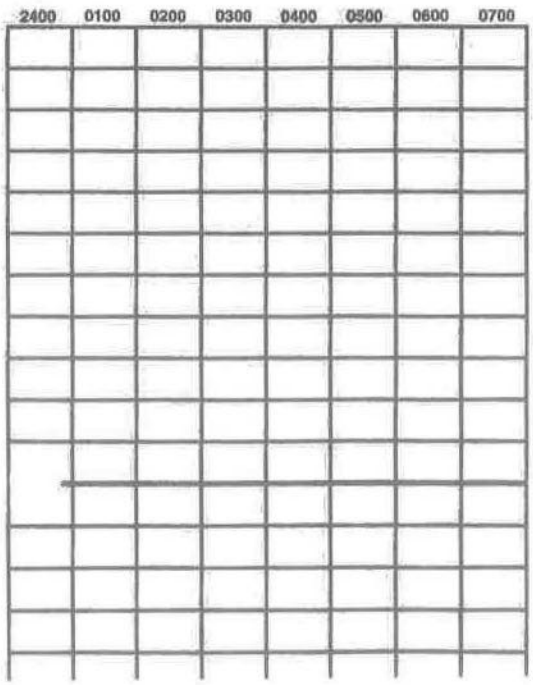
1600	1700	1800	1900	2000	2100	2200
100	100	100	100	100		

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 1 of 4
RN
RN
Date 4/20/09

MED0987







Nurses' Progress Notes

Nursing note outcome #1 pt on RA throughout shift, BS clear, no ↑ WOB, says 100%. will monitor Resp status closely. #2 pt continues on phenobarb. Neurology at bedside this am, orders recieved to DC continuous EEG monitoring & to give loading dose of phenobarb (goal LVL >35) pt also transitioned to ND phenobarb & IV loading dose given. No seizure activity noted, continuing q 2° neuro checks. Moving all extremities but stiff movements noted. MRI & Anesthesia scheduled for ~~1730~~ 5/1 at 1200. Will continue to monitor neuro status closely. #3 pt fussy this shift. Chloral hydrate dsd and ND valium started. Pt calmed & valium but easily arousable. Facc scores 0-4 Plan: Monitor Facc scores closely cont. valium as ordered. JHuddleston RN 2030-Plan for transfer to Peds Room 516 Parents informed - Report called to B. Armstrong RN @2100 — Tyl notified of transfer 2120 Transferred to Rm 516 — Y. Morrow RN

D = n...
Previous 24°

I 760
O 801
Today's Weight 7.1 kg
Yesterday's Weight 6.8 kg

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 1 of 4
Date 4/30/09
RN
RN

Assistive Devices
T - TEDS
A - Air Mattress
S - Splints
C - Compression Device

		0800	0900	1000	1100	1200	1300	1400	1500	8 hr Total	1600	1700	1800	1900	2000	2100	2200
INTAKE	Sim Adv	40	40/80	40/120	40/160	40/200	40/240	40/280	40/320	320	40	40/80	40/120	40/160	40/200		
	Med/Flush	3		3/6							3		13/16				
	TOTAL INTAKE ➤	0800	0900	1000	1100	1200	1300	1400	1500	320	1600	1700	1800	1900	2000	2100	2200
OUTPUT	URINE	115		10	80	30/85		sleep	110	285	80		50/130				
	STOOL/GUIAC	x1		x1					x1		x1						
	GASTRIC GUIAC/PH																
	CHEST TUBE																
	TOTAL OUTPUT ➤									285	635						
PRN MEDS	Tylenol	100mg 0800				100mg 1200					100mg 1600				100mg 2100		
	Fentanyl			11:30 14mcg													
	HEPARIN FLUSH																
MISC	OXIMETRY PROBE SITE	D				D					D						
	ACCUCHECK																
	HWE/C	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		
	Position	R	R	S	S	held	held	L	L		R	R	S	S	S		
	PROTECTIVE / SAFETY DEVICE																
	CIRC CHECK	✓		✓		✓		✓			✓		✓		✓		
	ASSISTIVE DEVICE																

tal	2400	0100	0200	0300	0400	0500	0600	0700	8 hr Total

TOTAL INTAKE ➤

2400	0100	0200	0300	0400	0500	0600	0700	

24*

TOTAL OUTPUT ➤

Room Check	0700 - 1900	1900 - 0700
BAG / MASK / SUCTION / DRUG SHEET	✓✓✓ JH	
SIDE RAILS / BED POSITION		
Alarm Parameters ON		

2 RN Signatures to verify IV Drip rates

0700 ❶ / ❷

1900 ❶ / ❷

VENTILATION

	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200
O_2 SOURCE	RA																		
FIO_2																			
MODE																			
RATE (IMV)																			
TV																			
PIP / PEEP																			
PS																			
SaO_2 (PULSE OX)																			
$ETCO_2$																			
pH																			
PCO_2																			
PO_2																			
HCO_2																			
BE																			
Art O_2 Sat (calc)																			
Art O_2 Sat (dir.)																			
VEN O_2 Sat (dir.)																			
NEB/ CPT																			
SUCTION																			

GLASGOW COMA SCALE

	CHILD/ADOLESCENT	INFANT	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0
EYES	4 Spontaneous 3 Open to Speech 2 Open to Pain 1 Remain Closed		4		4		4		4		4		4							
VERBAL	5 Oriented 4 Confused 3 Words 2 Sounds Only 1 No Response	Coos/Babbles Irritable Cry Cries to Pain Moans to Pain	4		4		4		4		4		4							
MOTOR	6 Obeys Commands 5 Localizes Pain 4 Withdraws 3 Abnormal Flexion 2 Extension 1 No Response	Spontaneous Movement Withdraws to Touch Withdraws to Pain	6		6		6		6		6		6							
		SEDATED Y / N	N		N		Y		Y		Y		Y							
		TOTAL	14		14		14		14		14		14							

NEURO

PUPILS	RIGHT: Size/Reaction R		4B		4B		4B		4B		4B		4B							
	LEFT: Size/Reaction L		4B		4B		4B		4B		4B		4B							
Fontanelle: Fl - Flat Fu - Full B - Bulging T - Tense S - Sunken			FL		FL		FL		FL		FL		FL							
ARMS	5 Normal 4 Slightly Weak 3 Breaks Gravity 2 Does Not Break Gravity 1 Flicker 0 No Motor Response R		4		4		4		4		4		4							
	L		4		4		4		4		4		4							
LEGS	5 Normal 4 Slightly Weak 3 Breaks Gravity 2 Does Not Break Gravity 1 Flicker 0 No Motor Response R		4		4		4		4		4		4							
	L		4		4		4		4		4		4							
COUGH / GAG + OR -			++		++		++		++		++		++							
SUCK / SWALLOW + OR -			++		++		++		++		++		++							
PAIN SCALE *circle method:*			(cries) / faces / flacc / linear								(cries) / faces / flacc / linear									

☐ System Assessed, No Problem Identified

TIME 0800 INIT JH

1. Respirations: ☐ Shallow ☐ Labored ☐ Nasal Flaring ☐ Stridor ☐ Grunting ☐ Periodic

Retractions: ☐ Substernal ☐ Subcostal ☐ Intercostal ☐ Supraclavicular

MED0991

0500	0600	0700

Lab Values

TIME								
Glu								
BUN								
Creat								
Na								
K								
Cl								
CO_2								
ICA								
Hgb								
Hct								
Plts								
WBC								
PT								
PTT								
Glu / Ket								
Sg / pH								
bld / prot								

[redacted] G 08
FH 37373672 ACCT STRT
5M M ADM 04/20/09
W [redacted] N 04305493 PADM

Reference Range for unit based lab tests		
Accucheck: 70-100 mg/dl		
URINE DIPSTICK		
glucose	–	negative
bilirubin	–	negative
ketone	–	negative
blood	–	negative
ph	–	5.0-8.0
protein	–	neg.-trace
sp. gravity	–	1.001-1.035
occult blood in stool	–	negative
occult blood in gastric content	–	negative

0	0400	0500	0600	0700

s / flacc / linear

INIT ____ ☐ NO PROBLEM

Hours Post Dose →							
DRUG LEVELS: Phenobarb	31						

PUPIL SCALE

B = Brisk S = Sluggish N = Non-react

1 2 3 4 5 6 7 8 mm

LINEAR ANALOGUE PAIN SCALE

No Pain — Excruciating Pain

0 1 2 3 4 5 6 7 8 9 10

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 3 of 4

RN
RN

Date 4/20/09

0700-1900 INITIAL	1900-0700 INITIAL

MED0992

RESPIRATORY

a. Secretions: Color [illegible] Amount: ☐ Scant ☐ Moderate ☐ Copious
Consistency: ☒ Thin ☐ Thick ☐ Frothy ☐ Tenacious

4. Breath Sounds: Right side 5 Left side 5 agree

1. Clear 2. Crackles 3. Inspiratory wheezes 4. Exp. wheezes 5. Rhonchi 6. Stridor
7. Diminished 8. Absent

5. Chest Tubes: Type of Device ____ CM suction ____ ☐ Water Seal
Φ Location ____ ☐ Tidaling ☐ Air leak ____ ☐ Straight Drainage
Character of Drainage ☐ Serous ☐ Sero Sanguinous ☐ Sanguinous ☐ Cloudy

Comment cont RR, Sat monitoring

CARDIOVASCULAR

☐ System Assessed, No Problem Identified TIME 0800 INIT JH

1. Heart Rhythm: ☒ NSR ☐ Sinus Brady ☐ Sinus Tachycardia
☐ SVT ☐ Ventricular Dysrhythmia ☐ Junctional/Nodal
Pacemaker: ☐ Temporary ☐ Permanent ☐ Transvenous ☐ Epicardial
☐ Transcutaneous Mode ____ Rate ____
MA: AO ____ VO ____ Sensitivity A ____ V ____ AV Delay ____

2. Pulses: 0-Absent 1 Weak 2 Normal 3 Bounding
D-Doppler

Pulse	B	R	F	DP	PT	Carotid
R		2		2		
L		2		2		

CAPILLARY REFILL IN SECONDS

CFT: RUE	<3	LUE	<3
RLE	<3	LLE	<3

3. Heart Tones: ☐ Active Precordium ☒ Normal ☐ Murmur
☐ Gallup ☐ Rub ☐ Distant PMI ____

4. Edema: Φ ☐ Generalized ☐ Extremity ☐ Sacral ☐ Periorbital
☐ Other ____

5. Vascular Catheters:

Line Type	Location	Date of Insertion	Device	Site Condition
PIV	(R) Foot	4/28/09	Φ	Site c/d/i, flushes well
PIV	(L) AC	4/27/09	Φ	Site c/d/i; " "

PA catheter CM Insertion ____ CM Sheath ____

Comment cont. cardiac monitoring

INTEGUMENTARY

☐ System Assessed, No Problem Identified TIME 0800 INIT JH

1. Skin Turgor: ☐ Poor ☒ Taut
2. Skin Temperature: ☐ Cool ☐ Clammy ☐ Diaphoretic ☒ Warm ☐ Hot
3. Skin Color: ☒ Pale ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☐ Pink ☐ Red/Flushed
4. Rash/Lesions: Location / Type ____
5. Pressure Ulcers: Site ____ Site in cm ____
Stage: ☐ Red Area ☐ II Partial Thickness ☐ III Full Thickness ☐ Penetration to Muscle

Incision/Wounds/Drains: skin c/d/i
location / Condition:
Comment cont EEG completed @1100

BRADEN SCALE: 555 22
Total Score: ____

15 - 16	Low Risk
12 - 14	Mod Risk
≤ 11	Hi Risk

GI / GU

☐ System Assessed, No Problem Identified TIME 0800 INIT JH

1. Abdominal Palpitation: ☒ Soft ☐ Firm ☐ Distended ☐ Tender ☐ Rigid ☐ Girth ____
2. Bowel Sounds: ☒ Active ☐ Hyperactive ☐ Hypoactive ☐ Absent
3. Gastric Tube: Type NG Size 8F Measures (cm) 40 ☐ To suction ☐ To gravity drainage ☒ Feeding (intermittent/continuous)
Type ____ Size ____ Measures (cm) ____ ☐ To suction ☐ To gravity drainage ☐ Feeding (intermittent/continuous)
drainage: color ____ guiac ____
4. Urine Catheter: ☐ External ☐ Suprapubic ☐ Indwelling size ____ Date Inserted ____
Diapered color ____ ☐ Cloudy ☐ Sediment ☐ Fruity Smell ☐ Foul Smell

Comment

INOVA HOSPITAL FOR CHILDREN
PICU Flowsheet
page 4 of 4
RN JH
RN
Date 4/30/09

NEURO	Comments: prn fentanyl	JH	
NUTRITION	Diet: TF	JH	
	Formula: Similac 20	JH	
	☐ NG ☒ ND/NJ ☐ GT ☐ po	JH	
	☒ Total feed ☐ Needs assistance ☐ Feeds self	JH	
ALLERGIES	NKDA	JH	
_ INIT____ ☐ NO PROBLEM			
PSYCHOSOCIAL	☐ Communications Barrier		
	☒ Unable to assess: ☐ Pt. ☐ Family		
	☐ Coping Ineffective: ☐ Pt. ☐ Family		
	☐ Fears:		
	Pain ☐ Pt. ☐ Family		
	Dying ☐ Pt. ☐ Family		
	Being Alone ☐ Pt. ☐ Family		
	☐ Emotional State:		
	Anxious ☐ Pt. ☒ Family	JH	
	Agitated ☐ Pt. ☐ Family		
	Tearful/Crying ☐ Pt. ☐ Family		
	Euphoric		
	☐ Parents: ☐ Called ☒ Visited	JH	
	☐ Pt./Parent Teaching ☐ Return demonstration		
	Comments:		
NURSING CARE / PROCEDURES	TRANSDUCERS: level / calibrated		
	Activity: ☒ total care ☐ need assistance ☐ self care	JH	
	HOB: ☐ flat ☐ 30° ☐ 45° ☐ 90°	JH	
	☐ other High Falls Precautions	JH	
	Bedrest / Turn Q2°	JH	
	Chair / HELD	JH	
	Ambulate ☐ on own ☐ with assist		
	ROM		
	Protective Device / RELEASE Q2°		
	Seizure Precautions		
	HYGIENE: Bath		
	Oral Hygiene	JH	
	Peri / Foley Care	JH	
	Skin Care	JH	
	~~Gastric~~ Tube Care ND	JH	
	Feeding Bag Rinsed / Changed	JH	
	Trach Care / Trach Changed		
	Cervical Collar Site Care		
	Line Tubing Changed / Injection Cap Changed		
	Carrier System Changed		
	IV Started / Location		
	PREP for test or procedure		
	x ray		
	other		
	NURSING CARE > 16 hrs day		
_ INIT____ ☐ NO PROBLEM			
_ INIT____ ☐ NO PROBLEM			

[redacted]
04305493 5M M FH 37373672 G [redacted] /08
PADM ADM 04/20/09 ACCT STRT

1SIGN

Date	Initials	Printed Full Name	Signature Including Title
4/20	KB	Tim Brickhouse	KBrickhouse RN
4/20	SJR	Suzanna Jay Ramsey	SJRamsey RN
4/20	MKB	Mary-Kate Butterbaugh	MKButterbaugh RN
4/21	CC	CARA CALDERON	CCalderon CCLS
4/21/09	KT	Kristin Taylor	KTaylor RN
4/22/09	LZ	Lynn Zuercher	LZuercher RN
4/22/09	LAE	Lura A Edwards	LAEdwards
4/23/09	SJ	Savannah Jenkins	SJenkins
4/23/09	KS	Kristen Self	KSelf RN
4-24-09	AW	Angela Wills	AWills
4/25/09	SK	Sarah Kelchlin	SKelchlin
4/25/09	DW	Danielle Williams	DWilliams RN
4/28/09	KA	Karen Amico	Karen Amico RN
4/29/09	JH	JHuddleston	JHuddleston
4/30/09	VR	Veronica Marlow	Veronica Marlow
5/1/09	kf	Kathy Funk	Kathy Funk RN
5/1/09	HS	Holly Senn	Holly Senn, CCLS
5/1/09	LK	LeeAnn Knight	LeeAnn Knight RN
5/2	SS	Sarah Stilling	Sarah Stilling RN
5/3/09	RA	Ronelle Armstrong	RArmstrong
5-4-09	TV	Tara Vanne	Tara Vanne RN
5-4-09	SR	Susan Raeder	SRaeder
5/5/09	RK	Rebecca Kuo	RKuo, RN
5/6/09	gw	Jessica Wagner	gwagner RN

PATIENT IDENTIFICATION

W [redacted]
M
04305493 4M M G [redacted] 08
PADM ADM FH 37373672
ACCT STRT

INOVA HEALTH SYSTEM
SIGNATURE LIST

CAT #81795 / R103008
PKGS OF 100

MR 1-20 MED0995

DISCHARGE SUMMARY
W[redacted] N[redacted]
Document ID: 140009
Admit Date: 04/20/2009
Discharge Date: 05/08/2009

Inova Fairfax Hospital
Inova Fairfax Hospital for Children
Inova Heart and Vascular Institute
3300 Gallows Road
Falls Church, VA 22042

INFECTIOUS DISEASE: Blood and urine cultures were obtained on the day of admission and were negative. In the PICU, patient spiked a temperature to 101.3 and sputum cultures showed pan sensitive Staph aureus and Strep pneumonia. The patient was started on IV ceftriaxone and continued a 7-day course with the final 5 days completed with Bactrim once his IV came out. The patient had no further fevers and remained afebrile throughout the remainder of his admission. He showed no additional signs or symptoms of infection through the remainder of his admission.

FEN/GASTROINTESTINAL: The patient was n.p.o. while intubated and maintained with D5 normal saline at maintenance. On April 23, a nasal duodenal tube was placed and he was started on goal feeds. Upon transfer out of the PICU onto the general pediatric floor, the patient had a speech eval with a swallow study to eval for ability to take p.o. feeds. Patient did well with no evidence of aspiration and p.o. feeds were slowly started. The patient did well with p.o. feeds and at time of discharge was tolerating full p.o. ad lib of Similac 20.

HEMATOLOGY: Patient was found to have an anemia in the PICU with an H and H of 7 and 22. Once enteral feeds were started the patient was started on elemental iron with improvement in his H and H. The patient did not require transfusion during this admission and remained on p.o. iron.

_____: Speech and PT, OT were consulted on April 22, to assess developmental status post injury. The patient was followed closely by PT/OT who reported daily improvement of his motor skills and interaction. He will have close followup, as well as outpatient speech, PT/OT upon discharge.

FACT: Homicide detectives were involved on the date of admission. CPS was called from the emergency department and a police investigation obtained a confession from the babysitter who shook the baby. Dr. Hauda from the child abuse team was consulted and skeletal survey was done. A skeletal survey on April 22 was negative for fracture, as well as a repeat skeletal survey on May 21. The patient will be followed by the FACT team as an outpatient.

SOCIAL: Social work was involved and psychology was consulted to help both parents deal with the injuries. Mom and dad remained at bedside throughout the admission and showed good coping skills.

FINAL DIAGNOSES:
Seizures, subdural hematoma, bilateral retinal hemorrhages, nonaccidental trauma.

CONDITION ON DISCHARGE:
Stable and improved.

DISCHARGE MEDICATIONS:
1. Phenobarbital 25 mg p.o. q.12 hours.
2. DIASTAT 1 gel q.12 hours p.r.n.
3. Methadone 0.5 mg p.o. q.12 hours. and a weaning schedule
4. Valium 0.45 mg p.o. q.8 hours. and a weaning schedule
5. Fer-In-Sol 1 mL p.o. daily.

INOVA FAIRFAX HOSPITAL
PRIMARY

W[redacted] N[redacted] G
DOB[redacted]008 M4M
Wt/Ht: 6.8 Kg
MedRec: 04305493
AcctNum: 37373672

Patient Data

Complaint: seizures
Triage Time: Mon Apr 20, 2009 15:19
Urgency: 1–ESI I
Bed: PEDS PEDS
Initial Vital Signs: 4/20/2009 15:21
BP: **R:**28
P:160 **T:**

ED Attending: Thornton, MD, Dawn
Primary RN: Welling, RN, Tracy
O2 sat:100 on 100%
Pain:

AMBULANCE (15:10 LBS)
NOTES: Age 5m, male, Pulse: 160, O2 sat: 99, **appeared to be choking seizing,bagging but assistein 3.3 rectal valium dexi 254. Babysitter gave rescue breaths and compressions. decerebrate posturing.**

TRIAGE (Mon Apr 20, 2009 15:19 JONI)
PATIENT: NAME: N[redacted] W[redacted], AGE: 100, GENDER: male, DOB:[redacted] 1908. (Mon Apr 20, 2009 15:19 JONI)
PROVIDERS: TRIAGE NURSE: Joan Grand, RN. (Mon Apr 20, 2009 15:19 JONI)
ADMISSION: URGENCY: 1–ESI I, AMBULANCE: ALS, TRANSPORT: 405M, DEPT: IFH MAIN EMERGENCY DEPT, BED: SOUTH TRAUMA–01. (Mon Apr 20, 2009 15:19 JONI)
COMPLAINT: COMPLAINT: seizures. (Mon Apr 20, 2009 15:19 JONI)
ASSESSMENT: Triage Assessment performed. (15:21 JONI)
VITAL SIGNS: Pulse: 160, Resp: 28, O2 sat: 100, 100%. (15:21 JONI)

KNOWN ALLERGIES
Nkda.

CURRENT MEDICATIONS (15:19 JONI)
None

VITAL SIGNS
VITAL SIGNS: Pulse: 160, Resp: 28, O2 sat: 100 on 100%, Time: 4/20/2009 15:21. (15:21 JONI)
BP: 92/57, Pulse: 131, Resp: 27, O2 sat: 100 on 100, Time: Mon Apr 20, 2009 15:27. (15:27 JONI)
BP: 103/71, Pulse: 156, Resp: bvm, O2 sat: 100, Time: 4/20/2009 15:30. (15:31 JONI)
BP: 101/63, Pulse: 154, Resp: bvm, O2 sat: 100, Time: 4/20/2009 15:32. (15:36 JONI)
BP: 108/67, Pulse: 154, Resp: bvm, O2 sat: 100, Time: 4/20/2009 15:34. (15:37 JONI)
BP: 101/60, Pulse: 148, Resp: 26, Temp: 95.9, O2 sat: 100, Time: 4/20/2009 15:34. (15:41 JONI)
BP: 88/64, Pulse: 148, Resp: 28, O2 sat: 100, Time: 4/20/2009 15:34. (15:49 JONI)
BP: –89–/–49–, Pulse: 165, Resp: 28, Temp: 35.5, O2 sat: 100, Time: Mon Apr 20, 2009 16:56. (17:07 TWEL)

PAST MEDICAL HISTORY (15:30 S041)
PEDIATRIC HISTORY: No past medical history.
PED MALE SURGICAL HISTORY: Patient has had no previous surgical history.
PED SOCIAL HISTORY: Patient attends Daycare, Lives at home with parents.
NOTES: Nursing records reviewed.

NURSING ASSESSMENT: HEAD–TO–TOE (15:57 JONI)
TIME ASSESSED: **This is a post–resuscitation assessment. Refer to Imaging section for the initial assessment on the trauma or cardiac flowsheet.**

INOVA FAIRFAX HOSPITAL
PRIMARY

W[redacted] N[redacted] G
DOB[redacted]/2008 M4M
Wt/Ht: 6.8 Kg
MedRec: 04305493
AcctNum: 37373672

HPI TRAUMA

CHIEF COMPLAINT: Patient presents for the evaluation of **?"choking/seizing"**. (15:29 S041)
HISTORIAN: History obtained from parent, History obtained from EMS. (15:29 S041)
MECHANISM: Complaint occurred by **unknown**. (15:29 S041)
OCCURRED: Onset was **this PM, Patient currently has symptoms**, Occurred at daycare. (15:29 S041)
NOTES: **4 mo M with no significant PMH BIBA p/w questionable choking/sz onset this PM while pt was at daycare. Per EMS, babysitter gave a few rescue breaths and comrpressions. +sz. A)patent B)BBS C)BP:102/58, HR:165 D)GCS=3 E)yes.** (15:57 S041)

ROS (18:13 KOOL)

CONSTITUTIONAL PED: No fever, No fussiness.
RESPIRATORY PED: No cough.
GI PED: No vomiting, No stool changes.
NOTES: All systems were reviewed and are negative for acute complaints except as described above.

PHYSICAL EXAM (18:21 KOOL)

CONSTITUTIONAL PED: Triage vital signs reviewed, Appears well hydrated, **actively seizing.**
HEAD PED: Atraumatic, Normocephalic, **Fontanel mildly bulging.**
EYES: **eyes deviated to RIGHT, pupils sluggish to react.**
ENT PED: Ears and nose normal to inspection, Oropharynx normal, Tympanic membranes normal.
NECK PED: Trachea midline, No masses.
RESPIRATORY CHEST PED: Breath sounds clear and equal bilaterally, **mild suprasternal retractions.**
CARDIOVASCULAR PED: RRR, Heart sounds normal.
ABDOMEN PED: Abdomen is soft, No distension, No masses.
GENITOURINARY MALE PED: External genitalia normal.
BACK: Normal inspection.
UPPER EXTREMITY: Inspection normal, No edema.
LOWER EXTREMITY: Inspection normal, No edema.
NEURO PED: **Pt actively seizing.**
SKIN: Skin is dry, Skin is normal color.
LYMPHATIC: No adenopathy in neck.

INTUBATION (15:46 CDAR)

INTUBATION: Emergent consent implied, Performed by resident, I was present for the entire procedure, Patient's airway is patent, **Patient being ventilated with bag valve mask, Airway suctioned**, Indication for intubation is respiratory failure, Oral–laryngoscopy intubation used, Patient sedated with benzodiazepine, Paralytic used: vecuronium, Patient was pre–oxygenated, Size of tube used is 3.5, Tube is cuffed, in 1 attempt, Tube visualized through cords, Breath sounds equal after intubation, OGT placed, Qualitative end tidal CO2 reading taken and confirms endotracheal intubation, Breath sounds heard bilaterally, no gurgling heard over epigastrium, Chest x–ray ordered to confirm placement, Patient tolerated procedure well, **Dr. Thorton at bedside for entire procedure**.

NGT/OGT (15:48 CDAR)

TIME OUT: Attending Name: Thorton.
NGT/OGT: Emergent consent implied, Performed by resident, I was present for the entire procedure, Nasogastric tube placement indicated for airway management, in the oropharynx, Description of output: Clear secretions returned, NG tube inserted after 1 attempt, Tube was clamped, No complications noted, Patient tolerated

procedure well.

DOCTOR NOTES

TIME: Time: 1520 . (16:07 KOOL)
Time: 1535. (16:09 KOOL)
Time: approx 1530. (16:32 JKUN)
Time: approx 1550. (16:38 JKUN)
Time: approx 1620. (16:41 JKUN)
Time: approx 1800. (19:18 KOOL)

TEXT: **Pt expiditiously intubated for periods of apnea with 1 episode of brief brady. Intubation supervised in entirety by attending. No complications.** (15:58 KOOL)
Head CT results d/w radiologist. +SDH. (16:04 KOOL)
Upon arrival pt with eyes deviated to RIGHT, generalized tonic activity, unresponsive. (16:07 KOOL)
After first versed dose pt with cessation of seizures, still unresponsive. (16:09 KOOL)
NSurg here. Wants Fosphenytoin load. (16:27 KOOL)
pt stopped seizing after first dose of versed. parents updated on patients condition. (16:32 JKUN)
after intubation pt had equal and BL breath sounds with good chest rise. pt's pupils equal and reactive. ant fontanelle bulging. heart RRR, pulse–140's, (+)femoral pulses BL, well perfused. (16:38 JKUN)
parents notified about CT results they understand that there will be a CPS case to r/o abuse. (16:41 JKUN)
reviewed CXR ETT in good place. (16:45 JKUN)
Placement of OGT supervised by attending. (19:17 KOOL)
d/w homicide detective. (19:18 KOOL)

CRITICAL CARE: Time: **Between 75 and 104 minutes, Total number of minutes spent in direct and indirect care of this critically ill patient excluding procedure time.** (19:18 KOOL)

PROVIDERS: First MD: Thornton. (15:20 S041)

D/W: Discussed with appropriate consultants, Discussed this case with Dr. Nsurg, Neurosurgery, **Agrees to see in ED.** (16:26 KOOL)
Discussed this case with Dr. Whitmer, the primary care physician, **PMD informed of pt's status and admission to PICU.** (19:16 KOOL)

DISPOSITION (18:06 TACK)

PATIENT: LAST LOCATION: PEDS, Disposition: Admit to PICU, Condition: 40 Critical, Remove from ER.

DIAGNOSIS (17:42 KOOL)

FINAL: PRIMARY: **Subdural hemorrhage ˇ traumatic**, ADDITIONAL: **Seizure.**

PRESCRIPTION: No recorded prescriptions

IMAGING

H AND P/PHYSICIAN CONSULTATION DOCUMENTS: Image captured from scanner. (17:08 VHIL)

EMS RECORD: Image captured from scanner. (18:50 VHIL)
Page 002 addedImage captured from scanner. (18:50 VHIL)
Page 003 addedImage captured from scanner. (18:50 VHIL)
Page 004 addedImage captured from scanner. (18:50 VHIL)
Page 005 addedImage captured from scanner. (18:50 VHIL)